

## PMH63

**TREND AND GEOGRAPHIC VARIATIONS IN THE LENGTH OF STAY FOR SCHIZOPHRENIA IN THE UNITED STATES**Sun SX<sup>1</sup>, Liu GG<sup>1</sup>, Luo X<sup>2</sup>, Fu AZ<sup>1</sup><sup>1</sup>University of North Carolina at Chapel Hill, Chapel Hill, NC, USA;<sup>2</sup>Duke University Medical Center, Durham, NC, USA

**OBJECTIVES:** To assess the national trend and regional variations in the length of stay (LOS) and medical practices for schizophrenia in the United States. **METHODS:** Schizophrenia inpatient care records were selected from the 1988 through 2000 National Inpatient Sample of Hospital Care Utilization Project (HCUP), a database that approximates a 20% sample of all US community hospitals. Using hospital and discharge sampling weights, national level estimates were produced to demonstrate the changes and patterns in LOS, medical practices, and associated demographic and clinical characteristics. **RESULTS:** The national average LOS for schizophrenia was found to have decreased from 16.22 days in year 1988 to 11.16 days in year 2000. Significant drop in LOS was observed from 1994 to 1998, but in all other years the changes were very small. The LOS varied substantially across geographical areas. In year 2000, the lowest LOS was 8.75 days in the Midwest, whereas in the Northeast LOS was nearly doubled at 16.18 days, and topped the national level. This difference was also accompanied by a sharp difference in medical practice between the two regions, that in the Midwest, individual psychotherapy (ICD-9-CM procedure code 9439) and electroshock therapy (code 9427) were the two most commonly used principal procedures, accounting for 27% and 15% respectively, whereas in the Northeast, psychiatric drug therapy (code 9425) was most common (38%), followed by other counseling (code 9449, 14%). In addition, there existed some regional differences in demographic and clinical characteristics. **CONCLUSIONS:** LOS for schizophrenia patients has decreased considerably from year 1988 to 2000 and differed significantly between different regions. These findings carry important policy implications regarding the relative efficiency, appropriateness and quality of hospital care in treating schizophrenia patients. Further studies are warranted to assess the patient health outcomes associated with the varied treatment patterns.

## PMH64

**MISDIAGNOSIS OF BIPOLAR DISORDER AS UNIPOLAR DEPRESSION**Stensland MD<sup>1</sup>, deLay N<sup>1</sup>, Ciaglia M<sup>2</sup>, Viswanathan S<sup>3</sup><sup>1</sup>Eli Lilly and Company, Indianapolis, IN, USA; <sup>2</sup>ZS Associates, Evanston, IL, USA; <sup>3</sup>ZS Associates, Boston, MA, USA

Bipolar disorder is frequently misdiagnosed as unipolar depression, in part, because of its episodic and cyclical nature. When a patient presents with symptoms of depression, a history of bipolar disorder precludes a unipolar depression diagnosis. **OBJECTIVE:** The objective of this study was to examine the rate that bipolar patients are misdiagnosed with unipolar depression in current practice. **METHODS:** To examine patterns of diagnosis, the PharMetrics Integrated Outcomes Database of adjudicated medical and pharmaceutical claims for over 3 million patients from 11 U.S. health plans was utilized. In this database, 3679 patients had two claims with ICD-9 diagnostic codes for bipolar disorder (296.0, 296.1, 296.4–296.8) that were not accompanied by a unipolar depression diagnostic code, age between 10 and 64, and 1 year of continuous eligibility prior to and following the initial bipolar diagnosis claim. **RESULTS:** In the 12 months prior to their initial bipolar diagnosis, 14% of patients had at least two claims for unipolar depression. In the 12 months following the initial bipolar diagnosis claim 32%

had at least two unipolar depression claims. When examining only patients who were diagnosed with bipolar disorder during an inpatients hospital stay, 47% were diagnosed with unipolar depression in the following 12 months. **CONCLUSION:** A disconcertingly high proportion of bipolar patients were diagnosed with unipolar depression following their initial bipolar diagnoses. These results suggest that greater physician education is needed regarding bipolar disorder and the importance of obtaining a history when patients present with symptoms of depression.

## PMH65

**SECOND SSRI SWITCHING AND DISCONTINUATION AFTER FLUOXETINE INITIAL THERAPY**Shaya F<sup>1</sup>, Mullins CD<sup>1</sup>, Meng F<sup>1</sup>, Wang J<sup>1</sup>, Harrison DJ<sup>2</sup><sup>1</sup>University of Maryland, Baltimore, MD, USA; <sup>2</sup>Pfizer, Inc, New York, NY, USA

**OBJECTIVES:** This study compares switching and discontinuation rates for patients who had already switched from fluoxetine to other branded selective serotonin reuptake inhibitors (SSRIs). **METHODS:** Retrospective analysis of claims in an administrative database from January 1, 1999 to June 30, 2002. Claims for patients on fluoxetine who switched to sertraline, paroxetine or citalopram were analyzed to compare rates of discontinuation or second switch to another SSRI. We used Cox proportional models and life table survival curves. Definition of switching or discontinuation was based on SSRI refill within 15 days or 2 days supply. **RESULTS:** Paroxetine patients (N = 217) were significantly more likely to switch (HR = 1.47, p = 0.033) than sertraline patients (N = 227). The likelihood of switching (HR = 0.98, p = 0.917) was not significantly different for patients on citalopram (N = 291) than on sertraline. Patients were as likely to discontinue when on sertraline (N = 324), paroxetine (N = 293) or citalopram (N = 437). Average number of distinct drugs (p = 0.0005) and average number of claims (p = 0.0006) were significant predictor of discontinuation, while age, gender and co-payment were not. **CONCLUSIONS:** Patients on fluoxetine who had switched to paroxetine were significantly more likely to switch again than those who had switched to sertraline. The likelihood of discontinuation was similar among patients on sertraline, paroxetine or citalopram.

## PMH66

**COMPARISON OF FIRST REFILL RATES AMONG BRANDED SSRI USERS**Mullins CD<sup>1</sup>, Shaya FT<sup>1</sup>, Meng F<sup>1</sup>, Wang J<sup>1</sup>, Bron M<sup>2</sup><sup>1</sup>University of Maryland, Baltimore, MD, USA; <sup>2</sup>Pfizer, Inc, New York, NY, USA

**OBJECTIVES:** Prior research documents that discontinuation rates among selective serotonin reuptake inhibitor (SSRI) users are high, but little is known about the likelihood of refilling at least one prescription. This study compares rates of first refills across SSRIs that remain on patent. **METHODS:** This retrospective cohort study used an administrative database from January 1, 1999 to June 30, 2002. Patients were followed up to 6 months after the first branded SSRIs. "Refill" was defined as refilling the first prescription for SSRIs of interest within 15 days or 1.5 times days supply. Logistic regression and sensitivity analyses examined the impact of age, gender, and co-payment as covariates. **RESULTS:** Based on descriptive analyses, sertraline, patients (N = 5590; 54.70% refill; p = 0.0001) or citalopram patients (N = 4124; 54.49% refill; p = 0.0008) were more likely to have a refill than paroxetine patients (N = 5201; 50.99% refill). These results were consistent with the logistic regressions where covariates were significant at the p < 0.10 but not the p